

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN9506</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/30/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>MT JULIET HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 001	1200-8-6 Initial Comments  Complaint investigation #30561, #30989, #31064, #31303, and #31579, were completed on April 23, 2013, through April 30, 2013, at Mt. Juliet Health Care. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 001			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6699

IPT411

If continuation sheet 1 of 1